

Medicare Claims Processing Manual

Chapter 28 - Coordination With Medigap, Medicaid, and Other Complementary Insurers

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(Rev. 666, 09-02-05)

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10 - Medigap - Definition and Scope

(Rev. 1, 10-01-03)

B3-4700

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990, Public Law 101-508) requires all Medicare supplemental (Medigap) insurance policies to conform to minimum standards including loss ratio requirements, standardized benefit packages and consumer protection requirements.

The procedures described in §§20 through 110 apply to all policies meeting the definition of Medicare supplemental insurance policies (“Medigap”) in §1882(g)(1) of the Social Security Act (the Act.)

A Medigap policy is: A group or individual policy of accident and sickness insurance, or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under §1876 or §1833 of the Act, or a policy issued under a demonstration project.

A Medigap policy is offered by a private company to those entitled to Medicare benefits and provides payment for Medicare charges not payable because of the applicability of deductibles, coinsurance amounts or other Medicare imposed limitations. Typically, a Medigap policy does not include limited benefit coverage areas available to Medicare beneficiaries, such as “specified disease” or “hospital indemnity” coverage. By law, the definition explicitly excludes a policy or plan offered by an employer to employees, or former employees, as well as policies offered by a labor organization to members or former members.

The National Association of Insurance Commissioners has developed model regulatory language for State insurance commissions to apply to Medigap insurance offerings. This model regulatory language is located at:
<http://www.carfra.com/products/medsupappendixb.pdf>. It recommends the requirements that states should consider for approving proposed Medigap insurance plans.

The following procedures for furnishing information are mandatory for Medigap plans. Contractors may enter similar arrangements with other insurers or State Medicaid plans for furnishing claims information. Medicaid agencies are furnished information in the standard format free of charge. Other payers must pay the Medicare costs for providing information.

20 - Assignment of Claims and Transfer Policy

(Rev. 138, 04-09-04)

B3-4702, B3-3047

A Medicare beneficiary who has a Medigap policy may authorize the participating physician, provider, or supplier of services to file a claim on his or her behalf and to receive payment directly from the insurer instead of through the beneficiary. In such cases, the intermediary or carrier must transfer Medicare claims information to the Medigap insurer. The Medigap insurer pays the physician/provider/supplier, and must pay the intermediary or carrier for their costs in supplying the information subject to limitations.

Paid claims from participating physicians or providers/suppliers for beneficiaries who have assigned their right to payment under a Medigap policy, regardless of whether or not it is in or from a State with an approved Medigap program, are to result in the transfer of claim information to the specified insurers.

The carrier systems must have the capability to distinguish between claims of participating and nonparticipating physicians and suppliers. This is because Medigap assignment of claims and transfer policy does not apply to nonparticipating physicians or non-participating suppliers.

Effective with the future implementation of CMS's consolidated Medigap claim-based crossover initiative, the process for reporting Medigap information on incoming claims will change. Each Part B and DME provider and supplier will only include the CMS-issued Medigap claim-based COBA ID, which will be assigned by CMS's Medicare Coordination of Benefits Contractor (COBC), if: 1) the provider or supplier participates in the Medicare Program and 2) the beneficiary has assigned his/her rights to payment under a Medigap policy to that provider or supplier. As part of a future instruction, CMS will require participating Part B and DME providers and suppliers to include the CMS-issued Medigap claim-based COBA ID on an incoming claim if they wish to have their patients' Medicare claims crossed over to a Medigap insurer that does not supply an eligibility file to identify its insureds.

20.1 - Beneficiary Insurance Assignment Selection

(Rev. 138, 04-09-04)

B3-4702.1, B3-3047, B4-2110.1

Beneficiaries indicate that they have assigned their Medigap benefits to a participating physician or supplier by signing block #13 on the Form CMS-1500. This authorization is in addition to their assignment of Medicare benefits as indicated by their signature in block #12.

The UB-92 makes no provision for the provider to indicate that the beneficiary has assigned benefits because the UB-92 is used only for institutional claims, for which payment is generally assigned to the provider of services. For claims the institutional provider submits to carriers for physician payments for physician employees; hospitals, SNFs, HHAs, OPTs, CORFs, or ESRD facilities may maintain a beneficiary statement in

file instead of submitting a separate statement with each claim. This authorization must be insurer specific.

If the beneficiary has a Medigap policy, the following statement should be signed:

HICN

NAME OF BENEFICIARY

MEDIGAP POLICY NUMBER

I request that payment of authorized Medigap benefits be made either to me or on my behalf to _____ for any services furnished me by that physician/provider/supplier. I authorize any holder of medical information about me to release to (name of Medigap insurer) any information needed to determine these benefits or the benefits payable for related services.

Since the beneficiary may selectively authorize Medigap assignments, caution providers about routinely stamping block #13 of the Form CMS-1500 "signature on file." The Medigap assignment on file in the participating doctor/supplier's office must be insurer specific. However, it may state that the authorization applies to all occasions of services until it is revoked.

Once CMS's COBA claim-based Medigap process becomes effective in the future, participating Part B and DME providers and suppliers will only include the CMS-assigned Medigap claim-based COBA ID on an incoming claim if confirmation that a beneficiary has authorized Medigap assignment has been obtained.

30 - Completion of the Claim Form

(Rev. 1, 10-01-03)

B3-2010 - 2010.3, B3-4702, PM-A-01-20, PM-A-01-63

Participating physicians and providers/suppliers must include Medigap policy information in the designated areas on the appropriate claims forms:

Form CMS-1500 (12/90) transmitted in ANSI X12N 837 COB (Version 4010) Transaction form or the National Standard Format (NSF). The NSF format is scheduled to be discontinued in October 2003.

Form CMS-1450 transmitted in the UB-92 format or the ANSI X12N 837 COB (Version 4010).

30.1 - Form CMS-1500 (ANSI X12N 837 COB (Version 4010))

(Rev. 138, 04-09-04)

B1-2010 - 2010.3, B3-4702, PM-A-01-20, PM-A-01-63

Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for all Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer. Medigap information is entered on the 1500 as follows:

Item 9a - The policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP. Note - item 9d must be completed if a policy and/or group number is entered in item 9a.

9b - The Medigap insured's 8-digit date of birth (MMDDYYYY) and sex.

Item 9c - Blank if a Medigap Payer ID is entered in item 9d. Otherwise, the claims processing address of the Medigap insurer. An abbreviated street address, two-letter postal code, and ZIP code copied from the Medigap insured's Medigap identification card is entered. For example:

1257 Anywhere Street
Baltimore, Md. 21204

Is shown as

1257 Anywhere St. MD 21204

Item 9d - 9-digit PAYERID number of the Medigap insurer - If no PAYERID number exists, the Medigap insurance program or plan name.

All the information in items 9, 9a, 9 b, and 9d must be complete and accurate. Otherwise, the Medicare contractor cannot forward the claim information. If prior arrangements have been made, the intermediary or carrier forwards the Medicare information electronically to the private insurer. Otherwise, the intermediary or carrier forwards a hardcopy of the claim to the private insurer.

A participating physician/supplier lists other supplemental coverage in item 9 and its subdivisions at the time each Medicare claim is filed.

Once CMS's COBA claim-based Medigap process becomes effective in the future, participating Part B and DME providers and suppliers will be required to enter the CMS-assigned claim-based COBA ID in block 9-D of Form CMS-1500 or in field NM109 of the NM1 segment in loop 2330B of the HIPAA 837 Professional claim or in field 301-C1 of the T04 segment of the NCPDP claim. If a participating Part B or DME provider or supplier fails to include this identifier in the field just described, the claim will not be transferred to the Medigap claim-based crossover insurer. (See §70.6 of this Chapter for more details.)

State Medicaid Agencies that participate in claim-based crossover will report the claim-based COBA ID assigned by CMS in block 9-D of Form CMS-1500 or in field NM109 of the NM1 segment in loop 2330B of the HIPAA 837 Professional claim or in field 301-

C1 of the T04 segment of the NCPDP claim. If a participating Part B or DME provider or supplier fails to include this identifier in the field just described, the claim will not be transferred to the State Medicaid Agency. (See §70.6 of this Chapter for more details.

30.2 - UB-92 (Form CMS-1450)

(Rev. 1, 10-01-03)

HO-460, A3-3604

The intermediary sends the full incoming claim records and the outbound COB records. See the CMS HIPAA Web page for the records, at <http://www.cms.hhs.gov/providers/edi/hipaadoc.asp>. The outbound records contain information about adjudication and payment of the claims, while the incoming records show the claim as received from the provider.

The provider must be sure that FL50 contains the identity of the Medigap insurer in sufficient detail for the intermediary to process the record to the Medigap payer. The intermediary is to inform providers of the identity and provider claims processing requirements of the Medigap payers with which it has a transfer agreement.

In the case of Medigap insurance, since Medicare is the primary payer, the provider would enter “Medicare” in FL 50 on line A and enter the Medigap insurer’s name in FLs 50 B. If Medicare is not primary, then the provider would enter the primary insurance payer(s) name in line A ahead of “Medicare” in FLs 50 Line B. The provider would enter the Medigap insurer’s name in order after “Medicare.”

FLs 52 - Indicates whether the provider has a signed release of information from the beneficiary on file (see §20.1).

FLs 60 - Shows the patient’s number under the Medigap insurance.

FLs 61 - Contains the insurance group or plan of the Medigap insurer if needed.

FLs 62 - Identification number, of code assigned by Medigap insurer if needed.

Note: For coordination of benefits between Medicare and payers other than Medigap that the intermediary has trading partner agreements with the same rules apply.

40 - MSN Messages

(Rev. 1, 10-01-03)

B3-4703, AB-99-3, AB-01-155

FI/Carriers should use the following messages, as appropriate, on the beneficiary’s MSN for each approved claim for which they have sent or will send a transaction to a Medigap insurer:

MSN # 35.1 - “This information is being sent to your private insurer(s). Send any questions regarding your benefits to them.” (**Note:** add if possible: Your private insurer(s) is/are).

MSN # 35.2 - “We have sent your claim to your Medigap insurer. Send any questions regarding your Medigap benefits to them.” (**Note:** add if possible: Your Medigap insurer is.).

FIs/carriers use the following messages, as appropriate, to explain why a transaction was not or will not be sent to the Medigap insurer:

MSN #35.3 - “A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer.”

MSN #35.4 - “ A copy of this notice will not be forwarded to your Medigap insurer because your provider does not participate in the Medicare program. Please submit a copy of this notice to your Medigap insurer.

MSN #35.5 - “We did not send this claim to your private insurer. They have indicated no additional payment can be made. Send any questions regarding your benefits to them.” (This would be expressed on a RA by the absence of transfer information.)

MSN #35.6 - “Your supplemental policy is not a Medigap policy under Federal and State law/regulation. It is your responsibility to file a claim directly with your insurer.”

MSN #35.7 - “Please do not submit this notice to them.” (Add-on to other messages as appropriate).

MSN’s must be sent in all instances except for the following claim types: laboratory, demonstrations, exact duplicates, and statistical adjustments. These four types require the suppression of notices.

50 - Remittance Notice Messages

(Rev. 138, 04-09-04)

B3-4704, PM-AB-99-3, PM-B-01-35, PM-A-01-57

Carriers/FIs should include the following message on remittance notices sent to participating physicians and suppliers when Medigap benefits are assigned and the information in block #9 of the Form CMS-1500 (or FL50 of the UB-92, as appropriate) is completed:

MA 18 – “The claim information is also being forwarded to the patient’s supplemental insurer. Send any questions regarding supplemental benefits to them.”

If the information in block #9 of the Form CMS-1500 or FL50 of the 1450 is incomplete, or more than one Medigap insurer was entered, FIs/carriers do not transmit a transaction record to the Medigap insurer. In such cases, the following message is included on the remittance advices.

MA19 - "Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer."

Beginning with July 6, 2004, implementation of the COBA parallel production period, intermediaries and carriers shall begin to follow the requirements specified in §70.6 of this Chapter with respect to the crossover information that is to be included on the provider's remittance advice. Beginning with the October 2004 systems release, intermediaries and carriers will include COBA trading partner names on the provider Electronic Remittance Advice (ERA) following receipt of a Beneficiary Other Insurance (BOI) reply trailer 29. (See §70.6 of this Chapter for more details.)

60 - Returned Medigap Notices

(Rev. 98, 2-06-04)

B3-4705, AB-99-3

Notices sent to Medigap insurers may be returned to the intermediary or carrier by the post office or other mail carrier as undeliverable. FIs and carriers consider returned notices as a source of information for detecting processing problems that merit additional analysis or investigation. They use findings to improve the transmittal process with respect to proper identification of the insurer or to update their Medigap insurer files. The intermediary or carrier should develop procedures to advise beneficiaries, physicians and suppliers of their responsibility for filing Medigap claims when a notice is returned but not re-transmitted. They should re-transmit notices that are returned due to their error.

If an insurer refuses to accept valid notices, FIs and carriers follow the procedures detailed in [§70.4](#).

Intermediaries and carriers shall cease this responsibility after CMS' Coordination of Benefits Contractor (COBC) has assumed full responsibility for claim-based Medigap process.

70 - Coordination of Medicare With Medigap and Other Complementary Health Insurance Policies

(Rev. 138, 04-09-04)

B1-4607, B3-4701, B3-4706, A1-1601; A3-3768 - 3769

For applicable policy on information sharing, see Pub 100-1, the Medicare General Information, Eligibility and Entitlement Manual, Chapter 6.

For applicable cost sharing policy, see Pub 100-06, the Medicare Financial Management Manual, Chapter 1.

A formal agreement is a prerequisite for the electronic transfer of such data. (See §80.3, “Medigap Electronic Claims Transfer Agreement”).

The intermediary or Carrier should determine the frequency at which they routinely transmit notices to all Medigap insurers but must transmit not less often than monthly. (See §70.4)

Data elements and the formats to be used are described on the CMS EDI Web site, at <http://www.cms.hhs.gov/providers/edi/hipaadoc.asp> under formats/coordination of benefits. As changes are made that site will be updated.

The CMS will begin efforts to consolidate the claims crossover process on a small-scale under the Coordination of Benefits Contractor (COBC) starting on July 6, 2004. Refer to §70.6 for Medicare contractor requirements and responsibilities beginning with that date.

Intermediaries, carriers, and DMERCs shall continue to pursue collection of unpaid debts from Medigap insurers and other existing trading partners, even if such entities have been transitioned to the COBA process.

70.1 - Authorization for Release of Information

(Rev. 1, 10-01-03)

B1-4600-4602.5, B3-10010, A1-1600 - 1602.5, A3-3768, A3-3769

See Pub 100-01, the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 6.

70.1.1 - Requests for Additional Information

(Rev. 1, 10-01-03)

Normally the standard EDI Coordination of Benefits formats are used to convey Medigap or other complementary insurance information. Where the Medigap or other complementary insurer requests title XVIII information for certain claims only, FIs and carriers treat the situation as a special request and determine the cost for providing it as described in Chapter 1 of Pub. 100-06, the Medicare Financial Management Manual.

If the request is for duplicate MSNs, the FI or carrier first informs the requestor that remittance remarks are included in the COB outbound claim records, and that there is a crosswalk from remittance remarks to MSN messages on the CMS Web site.

In the absence of a standing arrangement, the mere presence of an “authorization” to release and the identification of a complementary insurer on a title XVIII billing form

does not constitute a request for the “release” of information. The request for the information must be specific.

70.1.2 - Release of Title XVIII Claims Information for Medigap Insurance Purposes by Providers

(Rev. 1, 10-01-03)

HO-91.3

Subject to specific written beneficiary authorization, providers are permitted to furnish certain limited information about Medicare eligibility status and related claims information to third part payers for complementary insurance purposes. (See Chapter 6 of Pub 100-01, the Medicare General Information, Eligibility, and Entitlement Manual.)

70.2 - Integration of Title XVIII Claims Processing With Complementary Insurance Claims Processing

(Rev. 1, 10-01-03)

A3-3769

General

See Chapter 6 of Pub 100-01, the Medicare General Information, Eligibility, and Entitlement Manual for instructions about disclosure of information.

See Chapter 1 of Pub. 100-06, the Medicare Financial Management Manual, for requirements for determining costs.

70.2.1 - Program Recognition

(Rev. 1, 10-01-03)

Since title XVIII program identity must be maintained, notices and forms for title XVIII purposes must clearly identify their title XVIII origin. The complementary insurance notices and forms must be free of implication that the coordination of benefits constitutes an official endorsement by CMS of the complementary insurance plan. Also, they must not imply that title XVIII entitlement or enrollment is dependent upon the individual’s retention of his/her complementary insurance policy.

70.2.2 - Records and Information

(Rev. 1, 10-01-03)

A3-3769.C

See chapter 6, of Pub 100-01, the Medicare General Information, Eligibility, and Entitlement Manual.

70.2.3 - Matching Files Against Medicare Claims Files

(Rev. 1, 10-01-03)

A3-3769.D

See Chapter 6 of Pub 100-01, the Medicare General Information, Eligibility, and Entitlement Manual.

70.3 - Standard Medicare Charges for COB Records

(Rev. 138, 04-09-04)

A1-1600, B1-4601

See chapter 1, of Pub 100-06, the Medicare Financial Management Manual.

Once CMS has fully consolidated the claims crossover process under the Coordination of Benefits Contractor, that entity will have exclusive responsibility for the collection and reconciliation of crossover claim fees for those Medigap and non-Medigap claims that intermediaries and carriers send to the COBC to be crossed to trading partners.

70.4 - General Guidelines for Intermediary or Carrier Transfer of Claims Information to Medigap Insurers

(Rev. 1, 10-01-03)

B1-4607

See chapter 1, of Pub 100-06, the Medicare Financial Management Manual.

70.5 - Audits

(Rev. 1, 10-01-03)

B1-4601, A1-1601.C

See chapter 1, of Pub 100-06, the Medicare Financial Management Manual.

70.6 - Consolidation of the Claims Crossover Process

(Rev. 666, Issued: 09-02-05, Effective: 10-01-05, Implementation: 10-03-05)

The CMS has decided to streamline the claims crossover process to better serve our customers. Beginning with July 6, 2004, approximately ten COBA trading partners will

participate in the beta-site testing of the consolidated claims crossover or Coordination of Benefits Agreement (COBA) process. During this time, the COBA beta-site testers will participate in a parallel production crossover process (a pilot for only COBA trading partners using production/live data). During the parallel production period, the ten COBA trading partners will receive consolidated crossover claims as part of the COBA process. In addition, if the ten COBA trading partners have individual Trading Partner Agreements (TPAs) executed with Medicare contractors, they will receive crossover claims based on the terms and conditions of those TPAs. The Coordination of Benefits Contractor (COBC) will not charge the COBA beta-testers for crossed over claims during the parallel production period. Medicare contractors will, however, continue to charge these partners for claims that they continue to cross over to them during the beta-testing period.

Under the consolidated claims crossover process, trading partners will be transitioned from the current TPA process with Medicare contractors to new agreements called Coordination of Benefits Agreements (COBAs). These agreements, which will be negotiated on behalf of CMS by the COBC, will be entered into directly between CMS and the COBA trading partners. Through the COBA process, each COBA trading partner will send one national eligibility file that includes eligibility information for each Medicare beneficiary that it insures to the COBC. The COBC will transmit the beneficiary eligibility file(s) to the Common Working File (CWF) via a maintenance transaction. The transaction is known as the Beneficiary Other Insurance (BOI) auxiliary file. (See Chapter 27, §80.14, of Publication 100-4, Medicare Claims Processing Manual, for more details about the contents of the BOI auxiliary file.)

The CWF is being modified so that it will apply each COBA trading partner's claims selection criteria against processed claims with service dates that fall between the effective and termination date of one or more BOI records.

Effective with the January 2005 release, the *Part B* and DMERC *contractor* shared systems will be required to include an indicator "L" (beneficiary is liable for the denied service[s]) or "N" (beneficiary is not liable for the denied service[s]) in an available field on the HUBC and HUDC queries to CWF for claims on which all line items are denied. The liability indicators (L or N) will be at the header or claim level rather than at the line level.

For purposes of applying the liability indicator L or N at the header/claim level and, in turn, including such indicators in the HUBC or HUDC query to CWF, the *Part B* and DMERC *contractor* shared systems shall follow these business rules:

- The L or N indicators are not applied at the header/claim level if any service on the claim is payable by Medicare;
- The "L" indicator is applied at the header/claim level if the beneficiary is liable for any of the denied services on a fully denied claim; and

- The “N” indicator is applied at the header/claim level if the beneficiary is not liable for all of the denied services on a fully denied claim.

Currently, the DMERC contractor shared system is able to identify, through the use of an internal indicator, whether a submitted claim is in the National Council for Prescription Drug Programs (NCPDP) format. Effective with January 2005, the DMERC contractor shared system shall pass an indicator “P” to CWF in an available field on the HUDC query when the claim is in the NCPDP format. The indicator “P” should be included in a field on the HUDC that is separate from the fields used to indicate whether a beneficiary is liable for all services that are completely denied on his/her claim.

CWF shall read the new indicators passed via the HUBC or HUDC queries for purposes of excluding 100% denied claims with or without beneficiary liability and NCPDP claims.

After applying the claims selection options, CWF will return a BOI reply trailer (29) to the Medicare contractor only in those instances when the COBA trading partner expects to receive a Medicare processed claim from the COBC. Upon receipt of a BOI reply trailer (29) that contains (a) COBA ID (s) and other crossover information required on the HIPAA 835 Electronic Remittance Advice (ERA), Medicare contractors will send processed claims via an 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file to the COBC. The COBC, in turn, will cross the claims to the COBA trading partner. The CWF is also being modified in preparation for future receipt of claim-based Medigap and/ or Medicaid COBA IDs in field 36 of the HUBC or HUDC query. For claim-based crossover, CWF will also be equipped to search the Coordination of Benefits Agreement Insurance File (COIF) to locate a matching COBA IDs; apply the Medigap claim-based trading partner’s claims selection criteria; and return a claim-based reply trailer 37 to the *Part B* or DMERC *contractor* if a claim-based COBA ID has been located and the claim is to be sent to the COBC to be crossed over.

In addition, CMS shall arrange for the invoicing of COBA trading partners for crossover fees.

The effort to consolidate the claims crossover function will be implemented via a phased-in approach, beginning with a small-scale implementation on July 6, 2004, involving approximately ten COBA trading partners that will serve as beta-site testers.

CMS will not move trading partners into crossover production with the COBC any earlier than December 2004. Consequently, the COBA parallel production period will be extended until CMS, the Coordination of Benefits Contractor (COBC), and the participating beta-testing trading partners conclude the testing results demonstrate a high-level of confidence.

Contractors shall operate under the assumption that all of their existing eligibility file-based crossover trading partners will at least be in test mode with the COBC by the end of fiscal year 2005 (i.e., by September 30, 2005).

A. CWF Processing of the COBA Insurance File (COIF) and Returning of BOI Reply Trailers

Effective July 6, 2004, the COBC will begin to send initial copies of the COBA Insurance File (COIF) to the nine CWF host sites. The COIF will contain specific information that will identify the COBA trading partner, including name, COBA ID, address, and tax identification number (TIN). It will also contain each trading partner's claims selection criteria along with an indicator (Y=Yes or N=No) of whether the trading partner wishes its name to be printed on the Medicare Summary Notice (MSN).

Effective with the October 2004 systems release, the COIF will also contain a 1-digit Test/Production Indicator that will identify whether a COBA trading partner is in test (T) or production (P) mode. The CWF will be required to return that information as part of the BOI reply trailer (29) to Medicare contractors.

Upon receipt of a claim, CWF shall take the following actions:

- 1) Search for a COBA eligibility record on the BOI auxiliary record for each beneficiary and obtain the associated COBA ID(s) [NOTE: There may be multiple COBA IDs associated with each beneficiary.];
- 2) Refer to the COIF associated with each COBA ID (NOTE: The CWF shall pull the COBA ID from the BOI auxiliary record) to obtain the COBA trading partner's name and claims selection criteria;
- 3) Apply the COBA trading partner's selection criteria; and
- 4) Transmit a BOI reply trailer to the Medicare contractor only if the claim is to be sent, via 837 COB flat file or NCPDP file, to the COBC to be crossed over.

B. BOI Reply Trailer and Claim-based Reply Trailer Processes

1. BOI Reply Trailer Process

For eligibility file-based crossover, Medicare contractors shall send processed claims information to the COBC for crossover to a COBA trading partner in response to the receipt of a CWF BOI reply trailer (29). Medicare contractors will only receive a BOI reply trailer (29) under the consolidated crossover process for claims that CWF has selected for crossover after reading each COBA trading partner's claims selection criteria as reported on the weekly COIF submission.

When a BOI reply trailer (29) is received, the COBA assigned ID will identify the type of crossover (see the Data Elements Required for the BOI Aux File Record Table in Chapter 27, §24). Although each COBA ID will consist of a five-digit prefix that will be all zeroes, Medicare contractors are only responsible for picking up the last five digits within these ranges, which will be right justified in the COBA number field. In addition to the trading partner's COBA ID, the BOI reply trailer shall also include the COBA trading partner name (s), an "A" crossover indicator that specifies that the claim has been

selected to be crossed over, and a one-digit indicator [“Y”=Yes; “N”=No] that specifies whether the COBA trading partner’s name should be printed on the beneficiary MSN. As discussed above, effective with the October 2004 systems release, CWF shall also include a 1-digit Test/Production Indicator on the BOI reply trailer (29) that is returned to the Medicare contractor.

Larger-Scale Implementation of the COBA Process

Medicare contractors should note that the larger-scale COBA process, where additional trading partners are first identified as testing participants with the COBC and then are moved to crossover production with the COBC following the successful completion of testing, may be activated at any time during the COBA smaller-scale parallel production period. Activation of the larger-scale COBA process will most likely not occur before the early months of calendar year 2005.

MSN Crossover Messages

Effective with the October 2004 systems release, the Medicare contractor will begin to receive BOI reply trailers (29) that contain an MSN indicator “Y” (Print trading partner name on MSN) or “N” (Do not print trading partner name on MSN).

Also, effective with the October 2004 systems release, when a Medicare contractor receives a BOI reply trailer (29) that contains a Test/Production Indicator of “T,” it shall ignore the MSN indicator on the trailer. Instead, the Medicare contractor shall follow its existing procedures for inclusion of trading partner names on MSNs for those trading partners with whom it has existing TPAs.

When a COBA trading partner is in full production (Test/Production Indicator=P), the Medicare contractor shall read the MSN indicator returned on the BOI reply trailer (29). If the Medicare contractor receives an MSN indicator “N,” it shall print its generic crossover message(s) on the MSN rather than including the trading partner’s name. Examples of existing generic MSN messages include the following:

(For all COBA ID ranges other than Medigap)

MSN #35.1 - “This information is being sent to private insurer(s). Send any questions regarding your benefits to them.”

(For the Medigap COBA ID range)

MSN#35.2- “We have sent your claim to your Medigap insurer. Send any questions regarding your Medigap benefits to them.”

Beginning with the October 2004 systems release, contractors shall follow these procedures when determining whether to update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.

- 1.) If the Medicare contractor receives a BOI reply trailer (29) that contains a Test/Production Indicator "T," it shall not update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.
- 2.) If the Medicare contractor receives a BOI reply trailer (29) that contains a Test/Production Indicator "P," it shall update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.

Electronic Remittance Advice (835)/Provider Remittance Advice Crossover Messages

Beginning with the October 2004 release, when contractors receive a BOI reply trailer (29) that contains a "T" Test/Production Indicator, they shall not print information received from the BOI reply trailer (29) in the required crossover fields on the 835 Electronic Remittance Advice or other provider remittance advices that are in production. Contractors shall, however, populate the 835 ERA (or provider remittance advice(s) in production) with required crossover information when they have existing agreements with trading partners.

Beginning with the October 2004 release, when contractors receive a BOI reply trailer (29) that contains a "P" Test/Production Indicator, they shall use the returned BOI trailer information to take the following actions on the provider's 835 Electronic Remittance Advice:

- 1.) Record code 19 in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) of the 835 ERA (v. 4010-A1). [NOTE: Record "20" in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) when Medicare is the secondary payer.]
- 2.) Update the 2100 Loop (Crossover Carrier Name) on the 835 ERA as follows:
 - NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide.
 - NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 Implementation Guide.
 - NM103 [Name, Last or Organization Name]—Use the COBA trading partner's name that accompanies the first sorted COBA ID returned to you on the BOI reply trailer.
 - NM108 [Identification Code Qualifier]—Use "PI" (Payer Identification)

- NM109 [Identification Code]—Use the first COBA ID returned to you on the BOI reply trailer. (See line 24 of the BOI aux. file record)

If the 835 ERA is not in production and the contractor receives a “P” Test/Production Indicator, it shall use the information provided on the BOI reply trailer (29) to populate the existing provider remittance advices that it has in production.

CWF Sort Routine for Multiple COBA IDs

When a beneficiary’s claim is associated with more than one COBA ID (i.e., the beneficiary has more than one health insurer/benefit plan that pays after Medicare), CWF shall sort the COBA IDs and trading partner names in the following order on the returned BOI reply trailer (29): 1) Eligibility-based Medigap, 2) Supplemental, 3) TRICARE, 4) Others, and 5) Eligibility-based Medicaid. When two or more COBA IDs fall in the same range (see element 24 of the “Data Elements Required for the BOI Aux File Record” Table in chapter 27, §80.14 for more details), CWF shall sort numerically within the same range.

2. Medicare Summary Notice (MSN) and Electronic Remittance Advice (ERA) Crossover Messages During the Parallel Production Period

During the COBA parallel production period, which began July 6, 2004: 1) CWF will only return an “N” MSN indicator on the BOI reply trailer (29), in accordance with information received via the COIF submission; 2) If a “Y” indicator is returned, the Medicare contractor shall ignore it; and 3) the Medicare contractor shall follow its existing procedures for the printing of MSN crossover messages.

During the COBA parallel production period, Medicare contractors shall follow their current procedures for the reporting of crossover claims information in CLP-02 (Claim Status Payment) and in the NM101, NM102, NM103, NM108, and NM109 segments of Loop 2100 of the provider ERA. They shall also continue with their current procedure for inclusion of COB trading partner names on other kinds of provider remittance advices that you have in production.

3. Business Rules for Receipt of a CWF BOI Reply Trailer When Other Indicators of Crossover Are Present

COBA Parallel Production Period

During the COBA parallel production period, which began July 6, 2004, the Medicare contractor shall observe the following business rules when it receives a BOI reply trailer 29 and some other indication of crossover eligibility:

If the Medicare contractor receives a BOI reply trailer 29 with COBA IDs that fall in the ranges of 00001-89999, it shall continue to cross over claims a) per its existing TPAs and b) when Medigap or Medicaid information is reported on the claim. (**NOTE:** The preceding claim-based scenario does not apply to Part A contractors.) In addition, the Medicare contractor shall send claims for which it receives BOI reply trailers to the

COBC on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file. (**NOTE:** The COBA trading partner will only be charged for the claims that the Medicare contractor continues to cross to it during the parallel production period.)

During the parallel production period, the Medicare contractor shall not change its current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance. The Medicare contractor's Medicaid suppression logic should remain the same as today with its existing trading partners, even when it receives a BOI reply trailer that includes a Medicaid COBA ID.

Larger-Scale Implementation of the COBA Process

Beginning with the October 2004 release, Medicare contractors shall follow these rules when they receive a BOI reply trailer (29) that contains Test/Production Indicator "T" and there is some other indication of crossover eligibility:

If the Medicare contractor receives a BOI reply trailer (29) with COBA IDs that fall in the ranges of 00001-89999 (See Attachment A, element 24), it shall cross over claims 1) per its existing TPAs or 2) when Medigap or Medicaid information is reported on the claim (if that is how the *Part B* or DMERC *contractor* currently crosses over claims to Medicaid). (**NOTE:** Claim-based crossover scenarios only apply to *Part B and* DMERC *contractors*.)

In addition, the contractor shall send claims for which it receives BOI reply trailer to the COBC on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file.

When a COBA trading partner is in test mode, the contractor shall not change its current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance. The contractor's Medicaid suppression logic should remain the same as with current existing trading partners, even when you receive a BOI reply trailer (29) that includes a Medicaid COBA ID.

Beginning with the October 2004 release, contractors shall follow these rules when they receive a BOI reply trailer (29) that contains Test/Production Indicator "P" and there is some other indication of crossover eligibility:

1. If the Medicare contractor receives a BOI reply trailer (29) with a COBA ID that falls in the Medigap eligibility-based range (30000-54999), it shall not cross over claims based on an existing Medigap TPA or when Medigap information is reported on the claim. Instead, the Medicare contractor shall send the claim to the COBC (based on the BOI reply trailer 29) on the 837 v4010A1 flat file or NCPDP file for crossover by the COBC to the COBA trading partner. (**NOTE:** The assumption is that a beneficiary will have only one true Medigap insurer.)

2. If the Medicare contractor receives a COBA ID via a BOI reply trailer (29) that falls in the Supplemental range (00001-29999) and it has an existing TPA with a supplemental insurer for the beneficiary, it shall transmit the claim to the COBC for crossover to the COBA trading partner and cross the claim to your existing trading partner.
3. If the Medicare contractor receives a COBA ID via a BOI reply trailer (29) that falls in the Supplemental range (00001-29999), and it also receives Medigap crossover information on the claim, it shall cross the claim to the Medigap insurer identified on the claim and transmit the claim to the COBC for crossover to the COBA trading partner based on the Supplemental COBA ID.
4. If the Medicare contractor receives a COBA ID via a BOI reply trailer (29) that falls in the Medicaid range (70000-77999), it shall not cross over claims based on an existing Medicaid TPA or when Medicaid information is reported on the claim (if that is how the **Part B** or DMERC **contractor** currently crosses over claims to Medicaid). Instead, the Medicare contractor shall send the claim to the COBC (based on the BOI reply trailer 29) on the 837 v4010A1 flat file or NCPDP file for crossover by the COBC to the COBA trading partner.
5. If the Medicare contractor receives a BOI reply trailer (29) that contains a Medicaid COBA ID (70000-77999) and it has an existing TPA with a supplemental insurer or Medigap insurer, it shall suppress the Medicaid claim from inclusion on the COB 837 flat file or NCPDP file and cross the claim to the supplemental insurer.
6. If the Medicare contractor receives a BOI reply trailer (29) that contains a Supplemental COBA ID (00001-29999) or a Medigap eligibility-based COBA ID (30000-54999) and it has an existing TPA with Medicaid, it shall suppress its crossover to Medicaid but send the claim to the COBC.

NOTE: For the scenarios above, the trading partner shall be responsible for canceling any existing TPA that it has with the Medicare contractor once it has signed a COBA with the Coordination of Benefits Contractor (COBC).

C. Transmission of the COB Flat File or NCPDP File to the COBC

Regardless of whether a COBA trading partner is in test mode (Test/Production Indicator returned via the BOI reply trailer 29=T) or production mode (Test/Production Indicator returned via the BOI reply trailer 29=P), Medicare contractors shall transmit all non-NCPDP claims received with a COBA ID via a BOI reply trailer to the COBC in an 837 v.4010A1 flat file, as described in Transmittal AB-03-060. In a separate transmission, DMERCs shall send the claims received in the NCPDP file format to the COBC. Medicare contractors shall enter the 5-digit COBA ID picked up from the BOI reply trailer (29) in the 1000B loop of the NM1 segment in the NM109 field. In a situation where multiple COBA IDs are received for a claim, Medicare contractors shall send a separate 837 or NCPDP transaction to the COBC for each COBA ID. Medicare

contractors shall perform the transmission at the end of their regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare's final payment. Transmission should occur via Network Data Mover (NDM) over AGNS (AT&T Global Network Services).

Effective with October 4, 2005, when contractor systems transfer processed claims to the COBC as part of the COBA process, they shall include an additional 1-digit alpha character ("T"=test or "P"=production) as part of the BHT03 identifier (Beginning of the Hierarchical Transaction Reference Identification) that is included within the 837 flat file or NCPDP submissions. The contractor shared systems shall determine that a COBA trading partner is in test or production mode by referring to the BOI reply trailer (29) originally received from CWF for the processed claim. (See §70.6.1 of this chapter for further details about the BHT03 identifier.)

In addition, effective with October 4, 2005, the contractor shared systems shall submit separate 837 flat files or NCPDP files to the COBC—one that contains the BHT03 "test" identifier and another file that contains the BHT03 "production" identifier—in association with the file submission processes outlined above.

With respect to 837 COB flat file submissions to the COBC, Part B and DMERC contractors shall observe these process rules:

The following segments shall not be passed to the COBC:

- a) ISA (Interchange Control Header Segment);
- b) IEA (Interchange Control Trailer Segment);
- c) GS (Functional Group Header Segment); and
- d) GE (Functional Group Trailer Segment).

The 1000B loop of the NM1 segment denotes the crossover partner. If multiple COBA IDs are received via the BOI reply trailer, the contractor system shall ensure that a separate 837 transaction should be submitted for each COBA ID received. As the crossover partner information will be unknown to the standard systems, the following fields should be formatted as indicated for the NM1 segment:

NM103—Use spaces; and

NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows, with COBC completing any missing information:

NM1 segment—For NM103, NM104, NM105, and NM107, use spaces;

NM1 segment—For NM109, include HICN;

N3 segment—Use all spaces; and

N4 segment—Use all spaces.

The 2010BB loop denotes the payer name. Per the HIPAA Implementation Guide (IG), this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, given that the payer related to the COBA ID will be unknown by the standard systems, the NM1, N3, and N4 segments should be formatted as follows, with COBC completing any missing information:

NM1 segment—For NM103, use spaces;

NM1 segment—For NM109, include the COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);

N3 segment—Use all spaces; and

N4 segment—Use all spaces.

The 2330B loop denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BB loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:

NM103—Use spaces; and

NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2330B loop shall be repeated to allow for the inclusion of the name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

The 2320 loop denotes other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. The COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.

--SBR01—Treat as normally do.

With respect to 837 COB flat file submissions to the COBC, Part A contractors shall observe these process rules:

As the ISA, IEA, and GS segments are included in the '100' record with other required segments, the '100' record must be passed to the COBC. However, as the values for these segments will be recalculated, spaces may be placed in all of the fields related to the ISA, IEA, and GS segments.

The 1000B loop of the NM1 segment denotes the crossover trading partner. If multiple COBA IDs are received via the BOI reply trailer, the contractor system shall ensure that a separate 837 transaction should be submitted for each COBA ID received. As the crossover trading partner information will be unknown to the standard systems, the following fields should be formatted as follows for the NM1 segment on the '100' record:

NM103—Use spaces; and

NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows for the '300' record, with COBC completing any missing information:

NM1 segment – For NM103, NM104, NM105, and NM107, use spaces;

NM1 segment—For NM109, include HICN;

N3 segment—Use all spaces; and

N4 segment—Use all spaces.

The 2010BC loop denotes the payer name. Per the HIPAA IG, this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, since the payer related to the COBA ID will be unknown to the standard systems, the NM1, N3, and N4 segments should be formatted as follows for the '300' record, with COBC completing any missing information:

NM1 segment—For NM103, use spaces;

NM1 segment—For NM109, include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);

N3 segment—Use all spaces; and

N4 segment—Use all spaces.

The 2330B loop of the '575' record denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BC loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:

NM103—Use spaces; and

NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2330B loop shall be repeated to allow for the inclusion of the name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

The 2320 loop denotes other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. The COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.

---SBR01—Treat as normally do.

D. COBC Processing of COB Flat Files or NCPDP Files

When a Medicare contractor receives the reject indicator “R” via the Claims Response File, it is to retransmit the entire file to the COBC. If the Medicare contractor receives an acceptance indicator “A,” this confirms that its entire COB flat file or NCPDP file transmission was accepted. Once COB flat files or NCPDP files are accepted and translated into the appropriate outbound format(s), COBC will cross the claims to the COBA trading partner. The format of the Claims Response File that will be returned to each Medicare contractor by the COBC, following its COB 837 flat file or NCPDP file transmission, appears in the table below. (See §70.6.1 for specifications regarding the receipt and processing of the COBC Detailed Error Reports.)

Claims Response File Layout (80 bytes)				
Field	Name	Size	Displacement	Description
1.	Contractor Number	5	1-5	Contractor Identification Number
2.	Transaction Set Control Number/Batch Number	9	6-14	Found within the ST02 data element from the ST segment of the X12N 837 flat file or in field 806-5C from the batch header of the NCPDP file.
3.	Number of claims	9	15-23	Number of Claims contained in the X12N 837 flat file or NCPDP file. This is a numeric field that will be right justified and zero-filled.
4.	Receipt Date	8	24-31	Receipt Date of X12N 837 flat file or NCPDP file in CCYYMMDD format
5.	Accept/Reject indicator	1	32	Indicator of either the acceptance or rejection of the X12N 837 flat file or NCPDP file. Values will either be an “A” for accepted or “R” for rejected.
6.	Filler	48	33-80	Spaces

Claims response files will be returned to contractors after receipt and initial processing of a claim file. Thus, for example, if a Medicare contractor sends a COB flat file daily, the COBC will return a claim response file to that contractor on a daily basis.

COB 837 flat files and NCPDP files that will be transmitted by the Medicare contractor to the COBC will be assigned the following file names, regardless of whether a COBA trading partner is in test or production mode:

PCOB.BA.NDM.COBA.Cxxxxx.PARTA(+1) [Used for Institutional Claims]

PCOB.BA.NDM.COBA.Cxxxxx.PARTB(+1) [Used for Professional Claims]

PCOB.BA.NDM.COBA.Cxxxxx.NCPDP(+1). [Used for Drug Claims]

Note that “xxxxx” denotes the Medicare contractor number.

Medicare contractors shall perform the 837 flat file and NCPDP file transmission at the end of the regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare’s final payment.

Files transmitted by the Medicare contractor to the COBC shall be stored for 51 business days from the date of transmission.

The file names for the Claims Response File returned to the Medicare contractor will be created as part of the NDM set-up process.

Outbound COB files transmitted by COBC to the COBA trading partners will be maintained for 50 business days following the date of transmission.

E. The Future COBA Claim-Based Process Involving CWF

The CWF shall load the initial COIF submission from COBC as well as all future updates that pertain to claim-based Medigap insurers and State Medicaid Agencies.

Once claim-based crossover becomes effective in the future, CWF shall only search the COIF if the **Part B** or DMERC **contractor** has included a claim-based Medigap ID (55000-59999) or claim-based Medicaid ID (78000-79999) in field 36 of the HUBC or HUDC query. During the parallel production period (July 6, 2004, to October 1, 2004) and until the future implementation date for the claim-based COBA crossover process, CWF shall ignore claim-based COBA ID values if entered in field 36 of the HUBC or HUDC query.

Beginning with the implementation of the COBA claim-based crossover process, if claim-based COBA IDs are entered in field 36 of the HUBC or HUDC query, CWF shall:

- Search the COIF to locate the claim-based Medicaid and/or Medigap COBA ID and corresponding COBA trading partner name;

- Apply the Medigap claim-based trading partner's claims selection criteria;

- Return a Claim-based reply trailer 37 that includes values for claim-based COBA ID (sorted by Medigap, then Medicaid), COBA Trading Partner Name, and MSN Indicator when a claim-based COBA ID is found on the COIF and the claim is to be sent to the COBC to be crossed over;

- Return an alert code 7704 on the "01" response via a Claim-based alert trailer 21 to the **Part B** or DMERC **contractor** if a claim-based COBA ID in the Medigap claim-based range (55000-59999) is not located on the COIF; and

- Return nothing to the Part B and DMERC contractor if a Medicaid claim-based COBA ID (78000-79999) is not found on the COIF.

F. COBA Claim-Based Crossover Process

Until further notice from CMS, Part B and DMERC contractors shall not cease their existing claim-based Medigap and/or Medicaid crossover processes. Part B and DMERC contractors will receive COBA claim-based crossover requirements as part of a future instruction.

G. Transition to the National COBA and Customer Service Issues

1. Maintenance of Current Crossover Processes, Including Entry into New Claims Crossover Agreements (also known as Trading Partner Agreements or TPAs)

Medicare contractors shall keep their present crossover process in place, including invoicing for claims crossed to current trading partners, as described in Pub. 100-6, Financial Management, chapter 1, §450 and §460, until each of their present trading partners has been transitioned to the COBA process. Once CMS has fully consolidated the claims crossover process under the COBC, the COBC will have exclusive responsibility for the collection of crossover claim fees for those Medigap and non-Medigap claims that are sent to the COBC to be crossed over to trading partners. The COBC will also have responsibility for distribution of the collected crossover fees to Medicare Part A contractors and Part B contractors. (See also Pub.100-06, Chapter 1, §450.)

As trading partners are signed on to national COBAs, they will be advised that it is their responsibility to simultaneously cancel current agreements with the Medicare contractors and to cease submission of eligibility files. (NOTE: During the parallel production period, the COBA trading partner will be instructed by CMS to not cancel current TPAs with you.) By current estimates, CMS expects to at least have all current eligibility file-based trading partners in test mode by end of fiscal year 2005 (September 30, 2005).

Medicare contractors shall execute new TPAs only with trading partners that will be converted to full crossover production by April 1, 2005. Therefore, CMS expects contractors to cease execution of new crossover TPAs by January 31, 2005.

Trading partners that either wish to go into live crossover production after January 31, 2005, or have current questions regarding the COBA process shall be referred to the COBC at 1-646-458-6740.

2. Workload and Crossover Financial Reporting In Light of COBA

For workload reporting purposes, Medicare contractors shall provide counts for those claims that they individually cross to current trading partners (including Medicaid), just as they currently do in CAFM II and in CROWD. Medicare contractors shall separately track claims transmitted to the COBC for crossover to the COBA trading partners for future reporting requirements by COBA ID.

Effective with October 4, 2005, contractors or their shared systems shall report the number of claims submitted to the COBC via the 837 flat files or NCPDP files to their associated contractors' financial management staff only for those BHT03 (Beginning of Hierarchical Transaction Reference Identification) indicators that include a "P" in the final position of the BHT03 (position 22).

Reports generated by the contractors or their shared systems to the contractors' financial management staff shall include like data that are submitted following receipt of the COBC Detailed Error Reports to fulfill the necessary provider notification requirements. (Note: The Detailed Error Reports shall contain the same BHT03 identifier for purposes of reporting to financial management staff as was included by the contractor shared systems on the 837 flat file and NCPDP claim file submissions sent to the COBC.) [See §70.6.1 of this chapter for more information about the COBC Detailed Error Reports]. Minimum information for each BHT03 shall include claim counts sorted by COBA ID and shall be organized into groupings that allow for separate totals by Medicaid (COBA ID range=70000-77999), Medigap (COBA ID range=30000-54999), Supplemental (COBA ID ranges=00001-29999 and 60000-69999), and Other (COBA ID range 80000-89999), as well as grand totals for all less Medicaid.

3. Customer Service

a. COBA Parallel Production or COBA Testing Process

During the parallel production period, and while a COBA trading partner is in test mode with the COBC (Test/Production Indicator="T"), the Medicare contractor shall proceed with its current claims crossover customer service process. In addition, the Medicare contractor's claims history shall not be updated with crossover information based upon the receipt of a CWF BOI reply trailer (29).

b. Updating of the HIMR Detailed History Screens By CWF and the Larger Scale Implementation of COBA

Effective with the October 2004 release, when a COBA trading partner is in production mode (Test/Production Indicator=P), CWF shall annotate each processed claim on detailed history within the Health Insurance Master Record (HIMR) with an indicator that will inform all users of the claim's crossover status. (See Pub.100-04, Chapter 27, §80.15 for more information.). CWF shall allow for repeating of the application of crossover disposition indicators for up to ten (10) COBA IDs.

In addition, CWF shall annotate each processed claim with a 10-position COBA ID (5-digit COBA ID preceded by 5 zeroes) to identify the entity to which the claim was crossed or not crossed, in accordance with the COBA.

CWF shall not annotate processed claims on the detailed history screens in HIMR when a COBA trading partner is in test mode (Test/Production Indicator=T).

Effective with the October 2004 systems release, when a COBA trading partner is in production mode, the Medicare contractor's customer service personnel shall answer provider/supplier and beneficiary questions about a claim's crossover status by referring to your internal claims history. In

addition, the Medicare contractor's customer service staff shall access information regarding why a claim did not cross by referring to the detailed history screens on HIMR (e.g., INPH, OUTH, HOSH, PTBH, DMEH, and HHAH). [See chapter 27, §80.15 of the Medicare Claims Processing Manual for a listing of all claims crossover disposition indicators.] These screens will also display indicator "A" when a claim was selected by CWF to be crossed over to the COBA ID shown. The BOI auxiliary file will identify the name associated with the COBA ID. Such information may also be available to contractor customer service staff via the Next Generation Desktop (NGD) application.

The CWF maintainer will issue instructions on the use of the new HIMR screens as part of the October 2004 release.

70.6.1 - Coordination of Benefits Agreement (COBA) Detailed Error Report Notification Process

(Rev.666, Issued: 09-02-05, Effective: 10-01-05, Implementation: 10-03-05)

Effective with the July 2005 release, CMS will implement an automated process to notify physicians, suppliers, and providers that specific claims that were previously tagged by the Common Working File (CWF) for crossover will not be crossed over due to claim data errors. Claims transmitted via 837 flat file by the *Medicare contractor* systems to the COBC may be rejected at the flat file level, at a HIPAA ***ANSI X12N 837 COB*** pre-edit validation level, or by trading partners as part of a financial dispute arising from an invoice received. By contrast, claims transmitted via NCPDP file will be rejected only at the flat file and trading partner dispute levels. Effective with the April 2005 release, the *contractor* systems will have begun to populate the BHT 03 (Beginning of Hierarchical Reference Identification) portion of their 837 COB flat file submissions to the COBC with a unique ***22***-digit identifier. This unique identifier will enable the COBC to successfully tie a claim that is rejected by the COBC at the flat file or HIPAA ***ANSI X12N 837 COB*** pre-edit validation levels as well as claims disputed by trading partners back to the original 837 flat file submissions.

Effective with October 4, 2005, contractors or their shared systems will receive notification via the COBC Detailed Error Reports, whose file layout structures appear below, that a COBA trading partner is in test or production mode via the BHT 03 identifier that is returned from the COBC.

A. Inclusion of the Unique *22***-Digit Identifier on the 837 Flat File and NCPDP File**

1. Populating the BHT 03 Portion of the 837 Flat File

The *contractor* shared systems shall populate the BHT 03 (Beginning of Hierarchical Transaction Reference Identification; field length=30 bytes) portion of their 837 flat files that are sent to the COBC for crossover with a ***22***-digit Contractor Reference Identifier (CRI). The identifier shall be formatted as follows:

- a) Contractor number (9-bytes; until the 9-digit contractor number is used, Report the 5-digit contractor number, left-justified, with spaces for the remaining 4 positions);
- b) Julian date as YYDDD (5 bytes);
- c) Sequence number (5 bytes; this number begins with “00001,” so the sequence number should increment for each ST-SE envelope, which is specific to a trading partner, on a given julian date);
- d) Data Center ID (2 bytes; a two-digit numeric value assigned by CMS; see Table below for specific value for each contractor Data Center); *and*
- e) *COBA Test/Production Indicator (1-byte alpha indicator; acceptable values= “T” [test] and “P” [production]).*

The *22*-digit CRI shall be left-justified in the BHT 03 segment of the 837 flat file, with spaces used for the remaining *8* positions. (NOTE: The CRI is unique inasmuch as no two files should ever contain the same combination of numbers.)

Data Center Name	Data Center Identification Number for BHT 03 Field
AdminaStar Federal	01
Alabama (Cahaba)	02
Arkansas BCBS	03
CIGNA	04
EDS/MCDC2 (Plano)	05
EDS/MCDC2 (Sacramento)	06
Empire Medicare Services	07
Florida BCBS	08
Highmark	09
IBM/MCDC1 (Southbury, CT)	10

Info Crossing	11
Medicare Northwest/Regence of Oregon	12
Mutual of Omaha	13
South Carolina BCBS (Palmetto GBA)	14
TrailBlazer Health Enterprises	15
Veritus Medicare Services	16

2. NCPDP **22**-Digit Unique Identifier

The DMERC **contractor** system shall also adopt the unique **22**-digit format, referenced directly above under “Populating the BHT 03 Portion of the 837 Flat File.” However, the system shall populate the unique **22**-digit identifier in field 504-F4 (Message) within the NCPDP file (field length=35 bytes). The DMERC **contractor** system shall populate the new identifier, left justified, in the field. Spaces shall be used for the remaining bytes in the field.

B. COBC Institutional, Professional, and NCPDP Detailed Error Reports

The **contractor** systems shall accept the COBC Institutional, Professional, and NCPDP Detailed Error Reports received from the COBC. The formats for each of the Detailed Error Reports appear below.

The Institutional Error File Layout will be used for Part A claim files.

Field	Name	Size	Displacement	Description
1.	Date	8	1-8	Date Received (CCYYMMDD)
2.	Control Number	9	9-17	Transaction Set Control Number (Record 100, Field 26, ST02)
3.	COBA-ID	10	18-27	Receiver ETIN (Record 100, Field 55, NM109)
4.	Subscriber ID/HICN	12	28-39	Other Subscriber HICN (Record 590, Field 9, NM109)
5.	Claim DCN/ICN	14	40-53	Other Subscriber Secondary ID (Record 590, Field 17, REF02)

Field	Name	Size	Displacement	Description
6.	Record Number	9	54-62	Record Sequence number in dataset sent. <i>(NOTE: Will only be returned for claims with “111” error source codes.)</i>
7.	Record/Loop Identifier	6	63-68	Either Record Identifier (e.g., 100, 200, 300) or Loop Identifier (e.g., 1000A, 2010AA, 2300), left-justified.
8.	Segment	3	69-71	Segment Name
9.	Element	2	72-73	Element Name
10.	Error Source Code	3	74-76	Numeric value to identify source of error (e.g., flat file, HIPAA ANSI <i>X12N 837 COB</i> level, or trading partner dispute). The possible Error Source Codes for HIPAA Institutional claims are: 111= flat file error; 222=HIPAA ANSI <i>X12N 837 COB</i> file error; 333=trading partner dispute.
11.	Error /Trading Partner Dispute Code	6	77-82	Alpha-numeric Error /Trading Partner Dispute Code
12.	Error Description	100	83-182	Detailed Reason for Rejection
13.	Field Contents	50	183-232	Field Contents for Element in Error
14.	BHT 03 Identifier	<i>22</i>	<i>233-254</i>	An identifier that contains contractor number, julian date, sequence number, Data Center ID, <i>and COBA test/production indicator.</i>
15.	Filler	<i>50</i>	<i>255-304</i>	For future use/expansion.

The Professional Error File Layout will be used for Part B and DMERC claim files.

Field	Name	Size	Displacement	Description
1.	Date	8	1-8	Date Received (CCYYMMDD)
2.	Control Number	9	9-17	Transaction Set Control Number ST Segment, ST02 element
3.	COBA-ID	10	18-27	Receiver ETIN; 1000B Loop, NM1 segment, NM109 element
4.	Subscriber ID/HICN	12	28-39	Other Subscriber HICN; 2010BA Loop, NM1 segment, NM109 element
5.	Claim DCN/ICN	14	40-53	Other Subscriber Secondary ID; 2330B Loop, REF segment, REF02 element with REF01 = F8–
6.	Record Sequence Number	9	54-62	Record Sequence number in dataset sent. <i>(NOTE: Will only be returned for claims with “111” error source codes.)</i>
7.	Loop Identifier	6	63-68	Loop Identifier (e.g., 1000A, 2010AA, 2300), left-justified
8.	Segment	3	69-71	Segment Name
9.	Element	2	72-73	Element Name
10.	Error Source Code	3	74-76	Numeric value to identify source of error (e.g., flat file, HIPAA ANSI level, or trading partner dispute). The possible Error Source Codes for HIPAA Professional claims are: 111= flat file error; 222=HIPAA ANSI <i>X12N 837 COB</i> file error;

Field	Name	Size	Displacement	Description
				333=trading partner dispute.
11.	Error /Trading Partner Dispute Code	6	77-82	Alpha-numeric Error /Trading Partner Dispute Code
12.	Error Description	100	83-182	Detailed reason for rejection
13.	Field Contents	50	183-232	Field contents for element in error
14.	BHT 03 Identifier	22	233-254	An identifier that contains contractor number, julian date, sequence number, Data Center ID, <i>and COBA test/production indicator.</i>
15.	Filler	50	255-304	For future use/expansion

The NCPDP Error File Layout will be used for by DMERC *Contractors* for Prescription Drug Claims

Field	Name	Size	Displacement	Description
1.	Date	8	1-8	Date Received (CCYYMMDD)
2.	Batch Number	7	9-15	Batch number from the Header Record
3.	COBA ID	5	16-20	5-digit COBA ID.
4.	HICN	12	21-32	HICN (first 12 positions of the Patient ID field) in the G1/01 Record
5.	CCN	14	33-46	CCN from G1/00 record
6.	Record Sequence Number	9	47-55	Record Sequence Number in dataset sent. <i>(NOTE: Will only be returned for claims with</i>

Field	Name	Size	Displacement	Description
				<i>“111” error source codes.)</i>
7.	Batch Record Type	2	56-57	Batch Record Type from Header Record
8.	Segment ID	2	58-59	Segment ID from Header Record
9.	Error Source Code	3	60-62	Numeric value to identify source of error (e.g., flat file or trading partner dispute). The possible Error Source Codes for NCPDP claims are: 111= flat file error; 333=trading partner dispute.
10.	Error/ Trading Partner Dispute Code	6	63-68	Alpha-numeric Error/Trading Partner Dispute Code. (NOTE: Will not include Claredi-Faciledi HIPAA ANSI error codes.)
11.	Error Description	100	69-168	Detailed reason for rejection
12.	Field Contents	50	169-218	Field contents for element in error
13.	Unique File Identifier	22	219-240	<i>Equivalent to the BHT03 identifier used for the HIPAA 837 COB formats.</i> Included in field 504-F4 (Message) of the NCPDP claim (field length=35)
14.	Filler	50	241-290	Future use/expansion.

If a claim is rejected back to the *contractor* system for 2 or more COBA Identification Numbers (IDs), the *contractor* system shall receive a separate error record for each COBA ID. Also, if a file submission from a *contractor* system to the COBC contains multiple provider, subscriber, or patient level errors for one COBA ID, the system will receive a separate error record for each provider, subscriber, or patient portion of the file on which errors were found.

C. Further Requirements of the COBA Detailed Error Report Notification Process

1. Error Source Code

Contractors, or their shared systems, shall use all information supplied in the COBC Detailed Error Report (particularly error source codes provided in Field 10 of Attachment B) to (1) identify shared system changes necessary to prevent future errors in test mode or production mode (Test/Production Indicator=T or P) and (2) to notify physicians, suppliers, and providers that claims with the error source codes “111,” “222,” and “333” will not be crossed over to the COBA trading partner.

DMERC *contractors*, or their shared system, will only receive error source codes for a flat file error (“111”) and for a trading partner dispute (“333”). Both error types shall be used to identify shared system changes necessary to prevent future errors and notify physicians, suppliers, and providers that claims with error source codes of “111” and “333” will not be crossed over to the COBA trading partner.

2. Time frames for Notification of Contractor Financial Management Staff and Providers

Contractors, or their shared systems, shall provide notification to contractor financial management staff for purposes of maintaining an effective reconciliation of crossover fee/ complementary credit accruals within five (5) business days of receipt of the COBC Detailed Error Report.

Effective with the October 2005 release, contractors and their shared systems shall receive COBC Detailed Error Reports that contain BHT03 identifiers that indicate “T” (test) or “P” (production) status for purposes of fulfilling the provider notification requirements. (Note: The “T” or the P” portion of the BHT03 indicator will be identical to the Test/Production indicator originally returned from CWF on the processed claim.)

Special Automated Provider Correspondence

Contractors, or their shared systems, shall also take the following actions indicated below only when they determine via the Beneficiary Other Insurance (BOI) reply trailer (29) that a COBA trading partner is in crossover production mode with the COBC (Test/Production Indicator=P). After *a contractor*, or its shared system, has received a COBC Detailed Error Report that contains claims with error source codes of “111” (flat file error) “222” (HIPAA ANSI error), or “333” (trading partner dispute), it shall take the following actions within five (5) business days:

1. Notify the physician, supplier, or provider via automated letter from your internal correspondence system that the claim did not cross over. The letter shall include specific claim information, not limited to, Internal Control Number (ICN)/Document Control Number (DCN), Health Insurance Claim (HIC) number, Medical Record Number (for Part A only), Patient Control Number (only if it is contained in the claim), beneficiary name, date of

service, and the date claim was processed. In addition, the letter shall contain the following message: “The above claim(s) was/were not crossed over to the patient’s supplemental insurer due to claim data errors.” **NOTE:**

Contractors, or their shared systems, are not required to reference the COBA trading partner’s name on the above described automated letter, since the original remittance advice (RA)/electronic remittance advice (ERA) would have listed that information, if appropriate.

2. Update its claims history to reflect that the claim(s) did not cross over as a result of the generation of the automated letter.

80 - Electronic Transmission - General Requirements

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

Until an intermediary or carrier receives notice from a Medigap plan that it has signed a national Coordination of Benefits Agreement (COBA) with CMS’s Coordination of Benefits Contractor (COBC) and thus has requested cancellation of its existing Trading Partner Agreement with the Medicare contractor (see § 70.6 of this chapter for more information), intermediaries and carriers will continue to enter into formal agreements with individual Medigap insurers for the transmission of claim information electronically (see §80.3). The agreement should specify whether the Medigap insurer will submit an eligibility file. If the Medigap insurer wants to send a periodic eligibility file the agreement must specify how Medicare costs are to be paid by the Medigap insurer.

The CMS requires that the outbound format for the transfer of health care claim information is the ANSI X12N 837 COB, or for transmissions before the required implementation date for X12N, the NSF or UB-92 outbound format may be used. Also, if the recipient wants electronic attachments, attachment data must be furnished in UB-92 or NSF format because X12N does not support electronic attachments (e.g., UB-92 RTs 74, 75, 76). Only the attachment records will be furnished in UB-92 or NSF format after X12N becomes mandatory. Other data will be in the X12N format. The recipient must coordinate any attachments received with the claim record.

Detailed specifications on the electronic formats can be obtained at <http://www.cms.hhs.gov/providers/edi/edi3.asp>.

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as the COB data. The intermediary or carrier is required to receive all possible data on the incoming 837, although they do not have to process non-Medicare data. However, the shared system must store that data in a store-and-forward repository (SFR). This repository file is designed and maintained by the shared system. This data must be re-associated with the Medicare claim and payment data in order to create a compliant outbound COB transaction using the Medicare Claim/COB flat file as input. The shared system is to use post-adjudicative Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. This is to show any changes in data element

values as a result of claims adjudication. The shared system must retain the data in the SFR for a minimum of six months.

The Medicare Claim/COB flat file is the format to be used to re-associate all data required to map to the COB transaction. Until all trading partners have executed national COBAs and been moved into production with the COBC, the intermediary or carrier's translator will continue to build its outbound COB transaction from the Medicare Claim/COB flat file.

The CMS recommends that the intermediary or carrier send the outbound COB transaction over a wire connection. However, tape or diskettes may be sent to those trading partners that do not wish to receive transmissions via wire. The intermediary or carrier and its trading partners will need to reach agreement on telecommunications protocols. It is the intermediary or carrier's choice as to whether it wishes to process the X12N 997 Functional Acknowledgment from its COB trading partners.

Data on claims that the intermediary or carrier receives from its keyshop or image processing systems may not be included on the SFR, depending on the shared system design. The intermediary or carrier will create the Medicare claim/COB flat file using data available from claims history and reference files. Since some data will not be available on these "paper" claims, the outbound COB transaction will be built as a "minimum" data set. It will contain all "required" COB transactions segments and post-adjudicative Medicare data. For a Medicare Claim/COB flat file layout see <http://www.cms.hhs.gov/providers/edi/hipaadoc.asp>.

The steps from receipt of the incoming claim to creation of the outbound COB are summarized below:

- Contractor's translator performs syntax edits and maps incoming claim data to the X12N flat file;
- Standard system creates implementation guide and Medicare edits for the flat file data;
- Medicare data on ANSI X12N flat file is mapped to the core system;

NOTE: There are no changes in core system data fields or field sizes.

Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR; and adjudicated data is combined with repository data to create the outbound COB. Under the COBA process, the COBC will receive flat files containing processed Medicare claims. The COBC will then convert the flat files into the appropriate HIPAA outbound COB format and transmit the claims to the COBA trading partner. Implementation of this process will begin on July 6, 2004, with a small-scale parallel production period. Refer to §70.6 of this chapter for more details.

80.1 - HIPPA Provisions Affecting Medigap Transactions

(Rev. 1, 10-01-03)

PM-A-01-20

The HIPAA administrative simplification provisions have the following impact on data communications with Medigap and other complementary insurers.

- Medicare will switch to exclusive use of the outbound COB by October 16, 2003;
- Medicare will cease issuance of non-version 4010 COB transactions and acceptance of non-837 version 4010 electronic claims by October 2003;
- Medicare will cease support of DDE for Part B claims submission;
- Each provider that has elected to submit claims electronically must submit all of their claims in compliance with the HIPAA Implementation Guide (IG) requirements for ANSI X12N 837 version 4010. Vendors that submit electronic claims for Medicare providers must also comply with the IG requirements;
- Each trading partner that has elected to accept COB electronically must accept the IG outbound claim format, or contract with a [health] clearinghouse to translate its claim data from the IG format. An entity that elects to use a clearinghouse for translation services is liable for those costs; and
- COB trading partners must either request system compatibility testing for use of the COB transaction prior to October 2003, or be confident that they have completed system changes as required to accept production COB transactions by October 2003. Any trading partner that prefers to have COB testing conducted prior to transmission of production data must schedule testing with the intermediary or carrier as soon as possible to assure testing will be completed before October 2003. Current trading partners either accept production ANSI X12N 837 COB transactions starting October 2003, or advise their contractor that they are terminating their COB agreement. If the trading partner has not advised the FI or carrier which alternative it intends to pursue, the FI or carrier terminates sending COB transactions after September, 2003.

The Implementation Guide and X12N data dictionary can be downloaded without charge from www.wpc-edi.com/HIPAA.

There is no Medicare charge for furnishing test files for this system testing.

Medigap carriers should refer to <http://www.cms.hhs.gov/providers/edi/edi3.asp> for specifications for Version 6.0 of the COB UB-92 flat file as well as the NSF and ANSI X12N 837 formats.

80.2 - ANSI X12N 837 COB (Version 4010) Transaction Fee Collection

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

The intermediary or carrier charges Medigap and other complementary insurers (but not Medicaid) for the cost of preparing and sending COB transactions. The transfer agreement must include a description of data elements on the invoice (bill). (See §70.3 above.) Once CMS has fully consolidated the claims crossover process under the COBC, the COBC will have exclusive responsibility for the collection of crossover claim fees for those Medigap and non-Medigap claims that are sent to the COBC to be crossed over to trading partners. The COBC will also have responsibility for distribution of the collected crossover fees to Medicare intermediaries and carriers. (See also Pub.100-06, Chapter 1, §450 and Pub.100-04, Chapter 28, §70.6.)

If a Medigap insurer refuses to pay or does not pay it regularly and completely, the carrier should notify the appropriate State insurance commission that the Medigap insurer is not complying with the payment provisions of §4081 of OBRA 1987 (also found at §1842(h)(3)(B) of Title XVIII of the Act). First, the carrier should contact the insurance department of the State in which the policyholder resides. If that State insurance department does not accept jurisdiction, the carrier informs the appropriate RO. The RO contacts CMS Central Office for assistance in determining the department of jurisdiction. If, after contacting the insurance department recommended by CMS, the problem is unresolved, the carrier treats it as a CMS debt under 42 CFR 401.601-401.625. (**NOTE:** This responsibility shall cease once all Medigap insurers, including those that presently participate in mandatory Medigap [also known as “claim-based”] crossover as well as those that participate in eligibility file-based crossover, have been transitioned to the COBC).

The requirements in §§20 - 30.1 do not supplant existing agreements which the intermediary or carrier may have with any other insurer to exchange complementary insurance information except for possible amendment to recognize the beneficiary’s right to assign Medigap payment to participating physicians and suppliers on a claim-by-claim basis. The intermediary or carrier should modify these agreements to state that it is the beneficiary’s right to designate a particular insurer to receive a notice for payment. If the intermediary or carrier has transmitted an ANSI X12N 837 COB transaction to a designated Medigap insurer based on a properly executed assignment, that insurer should send claims information to other insurers under complementary arrangements.

80.3 - Medigap Electronic Claims Transfer Agreements

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

For electronic transfers occurring on a frequent basis, Medigap and other insurers must enter into agreements with the intermediary or carrier. These agreements may alter the procedures applying to existing agreements with complementary insurers, including Medigap assignment provisions.

At a minimum, all transfer agreements include:

- Functions of the carrier;

- Functions of the Medigap insurer;
- Fees and payment schedules;
- Confidentiality/Disclosure of information furnished;
- Office of Inspector General (OIG) review access;
- Contract periods and automatic renewal provisions;
- Contract termination provisions; and
- Dated signatures of authorized carrier/Medigap insurer representatives

Intermediaries or carriers can negotiate other provisions that the Medigap insurer may want but are not required to by §§20 - 80. The standard formats as described by these sections must be used.

By current estimates, effective with the end of fiscal year 2005 (i.e., September 30, 2005), all electronic transfer agreements [formally known as Coordination of Benefits Agreement (or COBAs)] will be negotiated and administered by the COBC, working on behalf of CMS. The COBAs will be executed between health insurers and health benefits programs that pay after Medicare and CMS rather than between intermediaries/carriers and these entities. Refer to §70.6 in this chapter for more details.

80.3.1 - Intermediary Crossover Claim Requirements

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

A. Outbound COB

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as COB data. Intermediaries are required to receive all possible data on the incoming ANSI X12N 837 although they do not have to process non-Medicare data. However, the shared system must store that data in a SFR. This repository file will be designed and maintained by the shared system. This data must be re-associated with Medicare claim and payment data in order to create an IG compliant outbound COB transaction using the Medicare Part A Claim/COB flat file as input. The shared system is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. The shared system must retain the data in the SFR for a minimum of six months.

The Medicare Part A Claim/COB flat file is the format to be used to re-associate all data required to map to the COB transaction. The translator will build the outbound COB transaction from the Medicare Part A Claim/COB flat file.

Intermediaries are not required to process an incoming ANSI X12N 997. They may create and use their own proprietary report(s) for feedback purposes.

The shared system maintainer must accommodate the COB transaction.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The small-scale implementation of COBA will begin July 6, 2004, with a parallel production period involving ten beta-tester trading partners. This parallel production process will continue until CMS, COBC, and the trading partners conclude the testing results demonstrate a high level of confidence. The larger-scale COBA process, where additional trading partners are first identified as testing participants with the Coordination of Benefits Contractor (COBC) and then are moved to crossover production with the COBC following the successful completion of testing, may be activated at any time during the COBA parallel production process. Activation of the larger-scale COBA process will most likely not occur before the early months of calendar year 2005.

B. Summary of Process

The following summarizes all intermediary steps from receipt of the incoming claim to creation of the outbound COB:

Intermediary's translator/edit process performs syntax edits, IG edits, and Medicare edits and maps incoming claim data to the Medicare Part A Claim/COB flat file;

Medicare data on the Medicare Part A Claim/COB flat file is mapped to the core system by the shared system.

NOTE: No changes are being made to core system data fields or field sizes;

Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR by the intermediary's shared system; and

Adjudicated data is combined with SFR data to create the outbound COB transaction.

For specifics on how the claims crossover process will change on a small-scale as early as July 6, 2004, under the COBA initiative, refer to §70.6 in this chapter.

80.3.2 - Carrier/DMERC Crossover Claim Requirements

(Rev. 448, Issued: 01-21-05, Effective: 02-22-05, Implementation: 02-22-05)

A. Outbound Coordination of Benefits (COB)

The outbound COB transaction is a post-adjudicative transaction. This transaction includes incoming claim data as well as COB data. Carriers are required to receive all possible data on the incoming ANSI X12N 837 although they do not have to process non-Medicare data. However, they must store that data in a store-and-forward repository (SFR). This repository will be designed by the shared system. This data must be re-associated with Medicare claim and payment data in order to create an outbound ANSI X12N 837 COB transaction. The shared systems maintainer is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. Carriers must retain the data in the SFR for a minimum of six months.

The ANSI X12N-based flat file is the format to be used to re-associate all data required to map to the outbound ANSI X12N 837. The translator will build the outbound ANSI X12N 837 COB from the ANSI X12N-based flat file.

The shared system maintainer must create the outbound ANSI X12N 837.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The small-scale implementation of COBA will begin July 6, 2004, with a parallel production period involving ten beta-tester trading partners. This parallel production process will continue until CMS, COBC, and the trading partners conclude the testing results demonstrate a high level of confidence. The larger-scale COBA process, where additional trading partners are first identified as testing participants with the Coordination of Benefits Contractor (COBC) and then are moved to crossover production with the COBC following the successful completion of testing, may be activated at any time during the COBA parallel production process. Activation of the larger-scale COBA process will most likely not occur before the early months of calendar year 2005.

B. Summary of Process

The following summarizes all the steps from receipt of the incoming claim to creation of the outbound COB:

- Carrier's translator performs syntax edits and maps incoming claim data to the ANSI X12N flat file;
- Standard system creates implementation guide and Medicare edits for the flat file data;
- Medicare data on ANSI X12N flat file is mapped to the core system;

NOTE: No changes are being made to core system data fields or field sizes.

- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the store-and-forward repository; and

- Adjudicated data is combined with repository data to create the outbound COB.

For specifics on how the claims crossover process will change on a small-scale as early as July 6, 2004, under the COBA initiative, refer to §70.6 in this chapter.

90 - Paper Submission

(Rev. 1, 10-01-03)

B3-4708

On paper submissions to Medigap insurers, the intermediary or carrier must include all of the same elements that are required on electronically transmitted claims notices **except** that the date of birth may be omitted. These elements are:

- Beneficiary Data;
- HICN;
- Name;
- Address;
- Date of Birth (not required);
- Medigap policy number;
- Claims Data;
- Medigap Assignment Indicator;
- Date of Service;
- Procedure Code (modifiers);
- Submitted Charge;
- Allowed Charge;
- Medicare Paid Amount;
- Amount Applied to Deductible;
- Part B Blood Deductible;
- Participating Physician/Supplier Data;
- Name;

- Address; and
- Tax Identification Number.

Medigap carriers that do not have trading partner agreements with the Medicare carriers or FIs usually receive paper claims consisting of Form CMS-1500 and UB-92 forms and/or Provider Remittance Advice (RA) from the provider. Medigap carriers that receive paper claims generally use claim level summary data to process and pay claims.

While Version 4A.01 of the electronic remittance advice will carry line-by-line payment and adjustment information that corresponds to each service line submitted on a claim, earlier versions of the electronic remittance advice and corresponding PC print version will support summary, claim level data only. Also the standard paper remittance advice reports summary, claim level payment data. There are no plans to change to include line level data.

100 - Medigap Insurers Fraud Referral

(Rev. 1, 10-01-03)

AB-00-23

Carriers and FI's should give high priority to fraud complaints made by Medicare supplemental insurers. If the referral by a Medigap insurer includes investigatory findings indicating fraud stemming from site reviews, beneficiary interviews, provider interviews and /or medical record reviews, contractors should (a) conduct an immediate data run to determine possible Medicare losses and (b) refer the case to the Office of the Inspector General (OIG).

In addition to the referral of such cases to the OIG, contractors should also identify and take additional corrective action to prevent future improper payments (e.g., by placing the provider or supplier's claims on prepayment review). Contractors are responsible for taking reasonable and appropriate measures to protect the Trust Fund.

110 - Medigap Criminal Penalties/Types of Complaints Under Section 1882(d)

(Rev. 1, 10-01-03)

RO-2700

Although most States have some type of penalty provisions regarding fraud and misrepresentation in the sale of health insurance policies, Congress considered that many State laws either did not directly address the following types of abuses, or else the sanctions generally available under State laws were considered too limited. Therefore, in order to provide an additional avenue for prosecution of these cases as well as to provide stiff penalties (fines up to \$25,000 and/or imprisonment for up to five years) these provisions were included in Section 507 of P.L. 96-265.

A. Section 1882(d)(1) - This paragraph prohibits the making of a false representation with regard to the compliance of a policy with the Federal requirements contained in this law. Additionally, it prohibits the making of any false statement or misrepresentation with respect to the use of the emblem that signifies the Secretary's certification of a policy under the Voluntary Certification Program. Policies submitted under this Voluntary Certification Program were accepted for review by the Medigap Operations Staff beginning January 1, 1982. Any agent or company which represents that its policy has received the Secretary's certification, or that its policy has received or is eligible for the Secretary's emblem, when, in fact, it has not received such certification or emblem, can be prosecuted under this paragraph. This paragraph became effective June 9, 1980.

B. Section 1882(d)(2) - This paragraph prohibits the false representation of an association or agency relationship with the Medicare program or any Federal agency for the purpose of selling insurance. Of the complaints received by CMS, the majority involves alleged violations of this paragraph. These complaints indicate that agents gained entry and, in some cases, sold policies by misrepresenting, either by direct statement or by implication, that they were associated with Medicare, CMS, or the Social Security Administration. This paragraph became effective June 9, 1980.

C. Section 1882(d)(3) - This paragraph provides penalties for knowingly selling duplicative coverage (sometimes referred to as "stacking" or "loading)." This occurs when an agent sells insurance to an individual knowing that it duplicates coverage that he/she already has without duplicating benefits. This paragraph became effective June 9, 1980.

Although many States have statutes that specifically prohibit "twisting" (misrepresentations made by an agent for the purpose of inducing the policyholder to lapse, forfeit, or convert a policy), few States have specific prohibitions against "stacking." Therefore, Federal prosecution under §1882(d)(3) may prove to be a useful approach where the available State statute does not specifically prohibit "stacking." Moreover, the Federal sanctions available for misrepresentations and "stacking" may prove to be useful for prosecution where the available State sanctions are more limited.

D. Section 1882(d)(4) - This paragraph provides penalties for knowingly soliciting, advertising, or offering for sale Medicare supplemental health insurance policies by mail into a State if these policies have not been approved by the Commissioner of Insurance for sale within the State or are not deemed to be approved for sale within the State. Section 1882(d)(4)(B) sets out the situations for deeming that a policy is approved within a State.

110.1 - Outline of Complaint Referral Process

(Rev. 1, 10-01-03)

RO-2700

Representatives of CMS, the Office of the Inspector General (OIG) and the Department of Justice (DOJ) have consulted to develop a coordinated procedure for the screening, investigation, and prosecution of cases arising under these penalty provisions.

The Fraud Section, DOJ, has expressed great interest in the prosecution of these cases and has sent an official communiqué to all U.S. Attorneys addressing the existence and importance of the Medigap law and alerting them to the probability of referrals of cases developed jointly by CMS, OIG, and by State Insurance Departments.

A. CMS/OIG Agreement

The CMS and OIG have reached the following agreement as to the division of functional responsibilities with regard to the screening and investigation of alleged violations of §1882(d):

1 - CMS, through its regional offices, is responsible for the preliminary screening of complaints and for providing information regarding the complaints to the appropriate State Insurance Department.

2. The OIG is responsible for the investigation of cases referred by the CMS RO and for coordinating investigatory activities with the State Insurance Departments if requested and warranted. Further, OIG will provide any necessary liaison between State Insurance Departments and the U.S. Attorneys.

B. CMS RO Responsibilities

Upon receipt of a complaint, the RO sends an informational copy of the complaint and any supporting documentation to the Regional Office of the Inspector General. The Special Agents in Charge will serve as the OIG contact point for CMS referrals.

Additionally, the RO sends a copy of the original complaint and any supporting documentation to the appropriate State Insurance Department. This is to be accompanied by a request for information as to the status of any State investigation regarding the same agent or company or the specific case in question.

1. If the State indicates that it is currently investigating, or intends to investigate the agent or company, the RO provides any information which may be helpful to the State and advise the State of the existence of the Federal penalty provisions and the availability of investigatory advice and/or assistance from the Regional Office of the Inspector General.

If the facts also indicate that a Federal violation may exist, the RO should keep the file open and request that the State advise them as to the status and, eventually, the disposition of the case.

If the facts indicate a possible State violation but no Federal violation, the RO out the case after referring it to the appropriate State Insurance Department.

In either event, the RO should respond to the complainant that the case has been referred to the State Insurance Department for investigation. The RO sends a copy of this response to the State, Regional OIG, and to the Medigap Operations Staff (MOS).

2. Where the State indicates that it does not plan to take action on the case, or where no response is received from the State within a reasonable period of time, i.e., not more than 30 days, the RO should proceed to screen the case. This activity consists of:

- Verifying the facts alleged in the complaint; and
- Determining whether the facts appear to constitute prohibited activity.

3. Where preliminary screening indicates that a mistake of fact exists, or that the facts do not indicate a Federal violation, the RO should respond to the complainant and attempt to clarify the misunderstanding. The RO sends a copy of the RO response to the complainant to MOS, the Special Agent in Charge, and the appropriate State Insurance Department.

Verification of Facts - The carrier or intermediary logs in complaints as they are received and establishes appropriate procedures to ensure that follow-up action is taken on any request for additional information. Verification of facts may include interviewing the complainant (either by phone or in person, as appropriate) to:

- Determine whether the facts, as originally reported, are accurate and precise;
- Clarify statements that are confusing or contradictory as originally recorded.
- Secure any missing or additional information; and
- Determine whether any similar complaints or additional information may be derived from others (e.g., relatives or neighbors).

In interviewing the complainant and others, keep in mind the substantive facts that may lead to prosecution. The carrier or intermediary uses the suggested format for referral to the Regional OIG as a checklist for the interview. As far as possible, the RO should keep the complainant informed of the status of the action taken on the complaint. So as to maintain a high level of cooperation; inform the complainant when he can expect to be contacted again, who will contact him, etc.

It is important that the RO **not** directly contact either the agent or the insurance company involved since this falls within the purview of investigation and is the function of the OIG.

Referral to the Regional Office of the Inspector General - When the preliminary screening process reveals an indication that the Federal law has been violated, refer the case to the Regional OIG for additional development. The OIG performs the necessary investigation and coordinates with the appropriate U.S. Attorney for prosecution. At this

point, CMS will cooperate with any request by the U.S. Attorney, State Insurance Department, and OIG to promote timely and successful prosecution.

If there should be any questions regarding this screening and referral activity, contact the Director, Medigap Operations Staff at the address below.

Centers for Medicare & Medicaid Services
Director, Medigap Operations Staff
7500 Security Blvd.
Baltimore, Maryland 21244-1850

110.2 - Preliminary Screening and Referral to Regional Office of the Inspector General

(Rev. 1, 10-01-03)

RO-2700

The Regional Office should perform preliminary screening activities, which may include interviewing the complainant in person or by phone (if appropriate), in order to reach a determination as to referral of the case for further investigation to the Special Agent in Charge, Office of Investigations, Regional Office of the Inspector General, HHS.

At the point where the RO believes that there exists an indication of the violation of one of the Federal penalty provisions, the RO should prepare a formal referral to the Regional OIG. In cases where there is uncertainty as to whether the Federal law has been violated, the case should be referred notwithstanding the uncertainty. The referral should reflect the following information:

- A. Type of violation, e.g., the complainant alleges a violation of §1882(d)(2);
- B. Name, address, and telephone number of the complainant; and
- C. A narrative description of the facts, which should include:
 - 1. All circumstances regarding the contact made by the subject with the beneficiary:
 - a. Type of contact (phone, personal);
 - b. Stated reason (if any) for selection of the beneficiary by the subject making the contact, e.g.:
 - i. Beneficiary lives in a senior citizens community or complex;
 - ii. The existence of another insurance policy with the same company; and

- iii. Referral by a third party.
- 2. Date, time, place, and duration of all contacts;
- 3. Words that were used to gain entry into the beneficiary's home, e.g., "I'm from Medicare," "...SSA," or other Federal Government agency;
- 4. Details of the subject's sales pitch or presentation:
 - a. Was there a discussion of the existence of other health insurance policies currently held by the beneficiary?
 - b. Did the agent know that his policy was duplicative of Medicare or a currently held policy?
 - c. Amount of premium of policy that agent was trying to sell. Obtain a copy of the policy if possible;
 - d. Existence of any hard sell or intimidation tactics on the part of the agent.
- 5. Details of the Agent's exit:
 - a. Business card left by agent; and
 - b. Follow-up calls by agent or others.

D. Other Information:

- 1. Name of contact person in the Regional Office;
- 2. Copy of the original complaint; and
- 3. Any other supporting documentation.

110.3 - CMS Regional Office Quarterly Report on Medicare Supplemental Health Insurance Penalty Provision Activity

(Rev. 1, 10-01-03)

RO-2700

The RO's should submit to the Director, Medigap Operations Staff, a report summarizing activities with regard to the screening and referral of complaints falling under the penalty provisions of §1882(d). This report will be used to compile the Secretary's report to Congress as required by §1882(f)(2). Under the terms of this paragraph, the Secretary must submit a report to Congress beginning July 1, 1982 (and at least every two years

thereafter) evaluating, among other things, the effectiveness of the criminal penalties. The following information from the Regional Offices is necessary for that evaluation.

110.3.1 - Statistics

(Rev. 1, 10-01-03)

RO-2700

The number of complaints received broken down by the type of alleged violation, e.g., §1882(d)(2).

The origin of the complaints:

- Complaint was made directly to RO;
- Complaint was referred by other Federal agency; State agency;
- Complaint was referred by consumer group;
- Other;
- The number of interviews (contacts) held to validate the facts of the case;
- The number referred (after screening) to the Regional Office of the Inspector General for investigation; and
- The number of cases closed-out:
 - o For mistake or misunderstanding;
 - o Referral to State for violations of State law;
 - o Other.
- The number of cases prosecuted and, for each, the name of the agent/company and disposition of the case; and
- The number of cases currently pending.

110.3.2 - Narrative

(Rev. 1, 10-01-03)

RO-2700

The RO provides information as to the overall success of the complaint validation and referral procedure including the extent of cooperation among CMS, OIG, State Insurance

Departments, and the U.S. Attorneys. This information will be used to correct or strengthen existing procedures.

This report should be submitted by the 15th of the month following the report quarter.